tax under chapter 43 of subtitle D of the Internal Revenue Code (relating to qualified pension, etc., plans), the transaction must be disclosed in the manner stated in such published guidance.

(b) *Effective date.* This section applies to transactions entered into on or after January 1, 2003.

[T.D. 9046, 68 FR 10170, Mar. 4, 2003]

§ 54.9801–1T Basis and scope (temporary).

(a) *Statutory basis.* Sections 54.9801–1T through 54.9801–6T, 54.9802–1T, 54.9811–1T, 54.9812–1T, 54.9831–1T, and 54.9833–1T (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope.* A group health plan may provide greater rights to participants and beneficiaries than those set forth in these portability sections. These portability sections set forth minimum requirements for group health plans concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to creditable coverage.

(4) Special enrollment periods.

(c) *Similar Requirements under the Public Health Service Act and Employee Retirement Income Security Act.* Sections 2701, 2702, 2704, 2705, 2721, and 2791 of the Public Health Service Act and sections 701, 702, 703, 711, 712, 732, and 733 of the Employee Retirement Income Security Act of 1974 impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. See 45 CFR parts 144, 146 and 148 and 29 CFR part 2590. See also Part B of Title XXVII of the Public Health Service Act and 45 CFR part 148 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801–2T).

[T.D. 8716, 62 FR 16927, Apr. 8, 1997; 62 FR 31691, June 10, 1997, as amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997; T.D. 8788, 63 FR 57553, Oct. 27, 1998]

§ 54.9801–2T Definitions (temporary).

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 54.9801–1T through 54.9801–6T, 54.9802–1T, 54.9811–1T, 54.9812–1T, 54.9831–1T, and 54.9833–1T.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of ERISA, section 4980B of the Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), and Title XXII of the PHSA.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or

(ii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual.

Condition means a medical condition.

Creditable coverage means *creditable coverage* within the meaning of § 54.9801–4T(a).

Employee Retirement Income Security Act of 1974 (ERISA) means the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Enroll means to become covered for benefits under a group health plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms

that are required in order to enroll in the plan. For this purpose, an individual who has health insurance coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions *(enrollment date* and *first day of coverage)* are set forth in § 54.9801–3T(a)(2) (i) and (ii).

Excepted benefits means the benefits described as excepted in § 54.9831–1T(b).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of *individual market* in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described in § 54.9831–1T(b)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHSA);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited duration insurance. For this purpose, short-term, limited duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date such contract becomes effective. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHSA, such term also includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

Issuer means a health insurance issuer.

Late enrollment definitions *(late enrollee* and *late enrollment*) are set forth in § 54.9801–3T(a)(2) (iii) and (iv).

Medical care has the meaning given such term by section 213(d) of the Internal Revenue Code, determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible/limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

Public health plan means *public health plan* within the meaning of § 54.9801–4T(a)(1)(ix).

Public Health Service Act (PHSA) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4T(b)(2)(iii).

Special enrollment date means a *special enrollment date* within the meaning of § 54.9801–6T(d).

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4T(a)(1)(vii).

Waiting period means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

[T.D. 8716, 62 FR 16928, Apr. 8, 1997; 62 FR 31691, June 10, 1997, as amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997; T.D. 8788, 63 FR 57554, Oct. 27, 1998]

§ 54.9801–3T Limitations on preexisting condition exclusion period (temporary).

(a) *Preexisting condition exclusion*—(1) *In general.* Subject to paragraph (b) of this section, a group health plan may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied. (See PHSA section 2701 and ERISA section 701 under which this prohibition is also imposed on a health insurance issuer offering group health insurance coverage.)

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-